NAMI Connecticut
National Alliance on Mental Illness

Testimony before the Select Committee on Children
March 6, 2012
Regarding HB 5347- An Act Concerning the Reporting of Children Placed in Seclusion
SB 293- An Act Concerning Permanency and Transition Plans

Good afternoon, Senator Gerratana, Representative Urban and members of the Children's Committee. My name is Daniela Giordano, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am here today on behalf of NAMI-CT to testify on both HB 5347- An Act Concerning the Reporting of Children Placed in Seclusion and SB 293- An Act Concerning Permanency and Transition Plans.

We thank the Children's Committee for raising HB 5347 and support it because we believe that it is extremely important that there be accurate and comparable data collection and reporting regarding the instances in which children in schools are restrained or placed in seclusion. This bill makes statutory changes to accomplish those goals.

While enactment of this bill would enhance our knowledge of frequency of use and allow us to compare data more readily across schools and geographic areas, this bill unfortunately does not address an issue of utmost concern to NAMI-CT: the use of seclusion in schools as part of an Individualized Education Program (IEP).

There is no evidence that seclusion has therapeutic value or enhances educational outcomes. ***We need to work with school administrators to train school staff and teachers to use positive behavioral interventions that have proven success in de-escalating problematic behavior***. We cannot allow schools to rely on seclusion as an effective treatment. CT should have the safest, most effective and humane teaching and learning environments in the country. That is not the case now. We can change that.

We propose that the limitations on the use of seclusion in schools be the same as the limitations that Connecticut currently places on the use of physical restraint, i.e., that seclusion be allowed in ***emergency situations only and not in an IEP***. The following states limit the use of seclusion to physical safety emergencies only or ban the practice entirely: Oregon, Colorado, Louisiana, Tennessee, Vermont, Wyoming, Georgia, Maine, Nevada, Pennsylvania and Texas.[1]

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[1] Jessica Butler, *How Safe Is The Schoolhouse? An Analysis of State Seclusion and Restraint Laws and Policies,* 14-5. The Autism National Committee. (January 20, 2012).

http://www.cpacinc.org/2012/01/analysis-of-state-seclusion-and-restraint-laws-and-policies/

There is no evidence-based research to suggest that the seclusion of a child is therapeutically effective. To the contrary, research demonstrates that seclusion can be both physically and psychologically harmful. Rather than seen as a way to promote self-regulation, experts generally view seclusion as a "treatment failure," as this practice actually promotes more emotional and behavioral disruptions.[2]

A child's Individualized Education Plan (IEP) documents the educational program to be provided by the school to a child with a disability so that the child receives a free appropriate public education. Because seclusion does not constitute an educational program, treatment, therapy or service, nor does it provide a student with a free appropriate public education, it should not be a part of an IEP.[3]

Rather, an IEP must include positive behavioral interventions, supports and de-escalation techniques that are proven to be effective methods in reducing problem behaviors and can actually increase classroom learning.[4]

Limited surveying done by the CT State Board of Education (SDE) produced alarming, if imperfect, data, with over 18,000 incidents of restraint or seclusion used in CT's public schools in school year 2009/10. This high number of (emergency) restraints and seclusions is of great concern to NAMI and points to a need for more positive behavioral support practices to be used in schools and better data reporting so that we have an accurate picture of the extent of the use of restraints and seclusion.

Improved data collection and data analysis along with ongoing staff training regarding the proper use of interventions are very much needed. Students' needs must be assessed on an individual basis, and addressed via state of the art, skill-building interventions. Introducing these approaches enhances the learning environment for everyone.

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[2] National Disability Rights Network (NDRN), School is Not Supposed to Hurt, 27. (January 2010).

http://ndrn.org/images/Documents/Resources/Publications/Reports/School-is-Not-Supposed-to-Hurt-NDRN.pdf

[3] National Disability Rights Network (NDRN), *School is Not Supposed to Hurt*, 27. (January 2010).

http://ndrn.org/images/Documents/Resources/Publications/Reports/School-is-Not-Supposed-to-Hurt-NDRN.pdf

[4] National Disability Rights Network (NDRN), *School is Not Supposed to Hurt*, 29. (January 2010).

http://ndrn.org/images/Documents/Resources/Publications/Reports/School-is-Not-Supposed-to-Hurt-NDRN.pdf

NAMI-CT supports SB 293 and we want to thank the Children's Committee for raising this bill. As part of the Keep the Promised (KTP) Coalition, a Connecticut coalition of advocates (people living with mental illness, family members, mental health professionals and interested community members) dedicated to ensuring that a comprehensive, community mental health system is created and sustained for children, adults and families in Connecticut, we have been advocating for effective transition planning for youth for numerous years.

Transition planning for youth sixteen years of age and older who are under the care of the Department of Children and Family (DCF) is crucial. Knowing what steps the department has taken to enable the youth to learn independent living skills and complete a secondary education or vocational program is important to ensure that youth leaving the system of DCF have the skills to live successful lives and provide for themselves.

It is crucial that the Department develop personalized transition plans that include specific strategies to address the following life areas and, where appropriate, provide assistance in accessing those: housing, health insurance, education, opportunities for mentors and ongoing support opportunities, work force support, employment services and benefits.

There is, however, one piece of this transition puzzle that is missing from SB 293. ***We must ensure that there is a coordinated and collaborative transition of youth from DCF to the Department of Mental Health and Addiction Services (DMHAS).*** There is a sizable population of youth that benefit from the proven supports and services at DHMAS, i.e., Young Adult Services (YAS). An average of 343 youth per year transition from DCF to DMHAS, translating into over 1,700 youth transitions in five years between 2007 and 2011. Young Adult Services benefits include housing subsidies, residential services, job training and education, clinical services and case management. These elements are not only important to document but to assure a safe and successful transition.

The costs of not ensuring safe and successful transitions are not only dire for the individual youth but also have significant economic consequences for the state including increased likelihood of youth dropping out of school, becoming homeless and unemployed, abusing drugs, attempting or contemplating suicide, and engaging in criminal activity.

We acknowledge that DCF and DMHAS have a Memorandum of Agreement (MOA) and have been collaborating in the past few years to improve transition planning for youth. However, currently there is no system to provide data in the process and outcomes. ***Our recommendation is to have Value Options, which now contracts with the State to manage behavioral health services for children and adults, collect and report data.*** It is our understanding that they can, under that contract, collect and report data related to these transitioning youth, such as:

- The number of youth identified at age fourteen as likely to transition;
- The numbers of youth accepted for adult services;
- The timeline and frequency of collaboration in developing and implementing a transition plan;
- The services provides to these youth to prepare them for transition; and
- The outcomes in the initial transition, engagement in adult services and success in independent living, including housing, education and employment.

Thank you for your time. I am happy to answer any questions you may have.
Respectfully yours, Daniela Giordano